ACSA
Aged & Community Services Australia

DEPARTMENT OF HEALTH

RESIDENTIAL AGED CARE: PROPOSED ALTERNATIVE MODELS FOR ALLOCATING PLACES

DISCUSSION PAPER

September 2019

ABOUT ACSA

Aged & Community Services Australia (ACSA) is the leading aged care peak body supporting church, charitable and community-based, not-for-profit organisations. Not-for-profit organisations provide care and accommodation services to about one million older Australians.[1]

ACSA represents, leads and supports its members to achieve excellence in providing quality affordable housing and community and residential care services for older Australians.

Aged care providers make a significant $17.6 billion economic contribution to Australia, representing 1.1% of GDP by producing outputs, employing people and through buying goods and services. The direct economic component is akin to the contribution made by the residential building construction and sheep, grains, beef and dairy cattle industries.[2]

ACSA members are important to the community and the people they serve, and are passionate about the quality and value of the services they provide, irrespective of their size, service mix or location.

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[1] Australian Government, Department of Health, Report on the Operation of the *Aged Care Act 1997*, December 2016.
[2] Deloitte Access Economics, Australia's aged care sector: economic contribution and future directions, Aged Care Guild, June 2016, page 24.

PROPOSED ALTERNATE MODELS FOR ALLOCATING RESIDENTIAL AGED CARE PLACES

BACKGROUND

As part of the *2018-19 Budget More Choices for a Longer Life* package, in principle support was provided to explore a move away from the current arrangement of allocating residential aged care places directly to providers, to an approach that provides greater consumer choice.

This measure is responding to the Legislated Review of Aged Care 2017[3] (Tune Review) in which three recommendations were made in relation the allocation of residential aged care places:

- Recommendation 3: Discontinue the ACAR for residential aged care places, instead assign places directly to consumers within the residential aged care cap, with changes to take effect two years after announcement;
- Recommendation 4: Announcement on ACAR discontinuation be accompanied by appropriate provisions to ensure continuing supply of residential aged care services in areas of limited choice and competition; and
- Recommendation 8b: In discontinuing the ACAR for residential aged care, review how best to ensure adequate supply and equitable access to residential respite care.

The Centre for Health Economics Research University of Technology Sydney, in partnership with business advisory firm StewartBrown and the Department of Health is undertaking an impact analysis of alternate arrangements for allocating residential aged care places that 'encourages a more consumer driven market[4]'.

The discussion paper[5] (the Paper) released by the Department of Health offers two models for consideration:

1. Model 1: Improve the ACAR and places management[6]; and
2. Model 2: Assign residential aged care places to consumers[7].

This is the discussion paper to which ACSA is responding.

[3] https://agedcare.health.gov.au/reform/aged-care-legislated-review

[4] Residential aged care: proposed alternative models for allocating places, Discussion paper, University of Technology, Sydney, July 2019

[5] Ibid

[6] Ibid, p17

[7] Ibid, p21

ACSA COMMENTARY

ACSA will need to analyse the recommendations of the study currently being undertaken before offering definitive comment, but we support in principle the direction being proposed.

We understand that the impact analysis being undertaken by UTS assumes that the current fiscal constraints on government expenditure for residential aged care will be retained[8], and therefore the total number of residential aged care places will continue to be 'capped'. Therefore, what is proposed in the two Models is not deregulation per se but may be considered further progress along that path.

Model 1 would appear to address a number of the identified deficits of the current allocations process (see *Current Arrangements* section below) and would likely be less disruptive than Model 2.

Model 2 is consistent with the direction of the Aged Care Roadmap[9] (the Roadmap) and other key reform documents of recent years commencing with the Productivity Commission Report of 2011[10] and the *Living Longer Living Better* reforms that followed[11], culminating in the recommendations of the Tune Review described on the preceding page.

If the changes proposed deliver innovation in service delivery and increased choice for consumers then individuals may more readily accept co-contributions (at current or increased levels).

There appears to be an assumption that innovation will automatically follow the introduction of Model 2. This assumption needs to be further tested, as there are likely a range of factors that drive innovation, including adequate funding to the sector.

Transition to either model, but particularly Model 2, will need to be carefully planned and managed to minimise negative impacts on consumers and the sector itself.

ACSAs comments about both models are provided in principle and the right to make definitive comment reserved until the findings and recommendations of the impact analysis currently being undertaken by UTS are made available to the sector for analysis and consideration.

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[8] Residential aged care: proposed alternative models for allocating places, Discussion paper, University of Technology, Sydney, July 2019, p22

[9] Aged Care Roadmap, Aged Care Sector Committee, March 2016

[10] Caring for Older Australians Productivity Commission Draft Report, Productivity Commission Australian Government, January 2011

[11] https://agedcare.health.gov.au/overview/response-to-the-senate-community-affairs-legislation-committee-report-on-the-aged-care-living-longer-living-better-bill-2013-provisions-and-related-bills

ACSA RESPONSES TO DISCUSSION PAPER QUESTIONS

Current Arrangements:

What works well under the current residential aged care allocation and places management for consumers and or providers?

Are there other issue/s with the current model for the allocation and management of places for residential aged care that have not been covered in this paper?

There are a range of characteristics of the current ACAR process that work well, including:

- The ACAR process allows for centralised planning by the Commonwealth Government for the provision of aged care places as prescribed in the Act[12], taking into consideration factors such as diversity of choice, special needs, continuity of care etcetera
- It provides a known process for applying for new licenses
- The allocation of provisional licenses to an approved provider provides a degree of income security when planning and financing aged care development/re-developments/expansions

Conversely the current ACAR process contains some negative characteristics:

- Negatively impacts incentives to innovate in service provision[13]
- Artificially limits 'choice' for consumers
- Creates a consultant's market and applications are judged on how well they are written rather than the value proposition
- The process is onerous, resource intensive and expensive for smaller providers
- There is a perception that gaining new licenses can be a 'lucky dip[14]'
- The capacity for a provider to effectively 'land bank' allocated places within a region, this can impact other providers from providing services within the same region in a timely manner
- Can be seen to financially support poor performing providers (although this largely comes down to the quality of the assessment process) by preventing alternate approved providers from providing quality services in direct competition
- Although normally an annual process, the lack of consistent timing of ACAR rounds makes it difficult for providers to be able to plan resourcing of applications
- Without licenses providers cannot expand into other areas[15]

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[12] Aged Care Act 1999, Part 2.2 Allocation of Places, Section 11-1

[13] Residential aged care: proposed alternative models for allocating places, Discussion paper, University of Technology, Sydney, July 2019, 12

[14] Ibid, p12

[15] Any current discussion of ACARs and 'locational controls' needs to acknowledge the *Aged Care Amendment (Movement of Provisionally Allocated Places) Bill 2019*[15], which passed its second reading in the House of representatives on the 11 September 2019. This amendment Bill will allow the Secretary to the Department of Health to allow approved providers of residential aged care to move provisionally allocated residential aged care places from one region to another within a state or territory. Whilst this loosens the locational controls, this does only relate to current approved places.

Design principles:

Are the proposed design principles appropriate?

Are there any other principles that you consider should be included?

We consider the design principles outlined in the discussion paper to be appropriate.

The intent to provide for a more 'consumer driven market[16]' is consistent with the intent of the Roadmap which also talks to a 'single aged care and support system that is market based and consumer driven, which access based on assessed need'.

The Roadmap describes a system where:

- Consumers will be able to choose the setting and the types of care and support they receive
- The market will respond to consumer demand; and
- Where the market can't or doesn't respond government will act as a safety net to ensure services are available and accessible to those in need[17]

Assigning the place to the consumer, which already happens in home care, will support providers to build and deliver services of a type and in a location where they believe there is a need and materially move towards the market approach described in the Roadmap.

Any such move will also need design principles that will maintain or improve "access to residential aged care and respite services, including in regional, rural and remote areas, thin markets and for vulnerable cohorts[18]'.

There is a risk that some providers, not just poorly performing providers, will not remain sustainable in this market-based approach. Strategies to ensure continuity and quality of care for residents are required including an approach for orderly exits of providers.

Current Deficits of ACAR or the 'case for change'

The paper describes:

- Limited choice as consumers can only select providers which have an available allocated place
- The ACAR process as administratively burdensome for providers (particularly for smaller providers with limited resources)
- Constraints on the market as providers cannot easily build or expand into other geographical areas in response to consumer demand[19]
- The time taken for a number of provisionally allocated places to come on line[20]
- Some providers applying for places to 'crowd out' local competition

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[16] Residential aged care: proposed alternative models for allocating places, Discussion paper, University of Technology, Sydney, July 2019, p16

[17] Ibid, p3

[18] Ibid, p16

[19] As stated elsewhere in this submission this is now partially addressed with the proposed *Aged Care Amendment (Movement of Provisionally Allocated Places) Bill 2019, albeit this Bill only related to currently allocated places*

[20] It is stated that around 13 per cent of allocated places are not constructed or opened, with construction said to take on average 4.3 years. Around 9 per cent of these provisionally allocated places have been allocated for 6 years or more.

An important consideration for the impact analysis is to what extent a 'simpler' solution (such as described by Model 1) addresses these identified deficits (including those identified in the *Current Arrangements* section above) versus Model 2's more comprehensive change?

ACSA's view is that Model 1 will move someway towards improving consumer choice by 'loosening' locational controls on providers (thereby allowing providers to move currently allocated places to regions where the provider believes there is unmet demand), however the proposed changes designed to reduce non-operational places will not automatically improve access to residential aged care places.

Making the ACAR process less administratively burdensome would be a positive outcome for all providers, particularly so for smaller providers with limited resources.

Increasing 'choice' for consumers, reducing constraints on providers being able to expand into new geographical areas, or reducing the incentive for a provider to 'bank' provisionally allocated places (to crowd out competition) would be better served by moving to Model 2.

Additionally, Model 2 is more in line with the direction set in the Aged Care Roadmap.

In terms of which Model will better promote innovation in the sector will need to be considered as part of the impact analysis work to be attended and acknowledging that there are a range of factors that foster/inhibit innovation, including financial viability.

Model 1. Improve the ACAR and places management

What are your views on the suggested improvements proposed under this model?

Model 1 describes:

1. Reducing the number of non-operational residential care places to maximise the availability of places to consumers; and/or
2. Improving the administration of the ACAR and places management process; and/or
3. Reducing locational controls on the distribution of residential care[21]

We believe that the identified deficits (as identified in the *Current Deficits of ACAR* section above) can likely be addressed, at least to some extent, by the three strategies listed above for Model 1, noting the following comments:

- There are already requirements on providers[22] that relate to bringing provisionally allocated places on line with a time frame that reflects the average time taken and allows some room for circumstances that are largely outside of a providers control (for example local government planning approvals). It is potentially the monitoring of progress that needs to be revised rather than the current legislative requirements. Any changes need to take these realities into consideration
- Loosening 'geographical controls' (on already allocated places) may go some way towards improving choice for consumers as providers may be able to distribute places more flexibly. This option is unlikely to be as effective as Model 2 which gives providers the freedom to build new places in any geographical location to meet unmet demand

[21] For the sake of this submission we are assuming 'reducing locational controls' refers to relaxing locational controls on provisionally allocated places within the state or territory that they were allocated

[22] Aged Care Act 1997, Subsection 15-7

- Addressing administrative complexity will assist providers in making applications. Additionally, introducing a process for 'out of rounds' applications, where a provider is looking for a relatively small number of places, may also help address unmet demand and increase consumer choice

In short, this Model retains the certainty of the ACAR for providers, thus retaining the benefits listed (in the *Current Arrangements* section above)

How can this model ensure/encourage adequate supply of and equitable access to residential aged care and residential respite care including:

- ***in RRR areas and thin markets, and***
- ***for consumers from vulnerable cohorts i.e. special needs groups?***

The proposed strategy in Model 1 to loosen 'locational controls' is likely to impact these identified areas and is a two-edged sword. Being able to move allocated places between geographical location could on the one hand increase choice and options for consumers but could also see places moved out of geographical areas or special needs provision which are less financially viable or appealing.

If 'locational controls' are loosened consideration to ensuring supply will be required. This could be addressed by excluding some areas and groups from the supply changes or introducing mechanisms, overseen by the Department of Health, to ensure continued provision by:

- Controlling the geographical movement of allocated places if the above cohorts are being disadvantaged; and/or
- Providing additional out-of-round, or one-off allocation of places with special conditions attached, to address shortfalls in these cohort groups

Implementation and transition considerations

How could implementation of this model maximise the benefits and minimize the risks/disruptions?

What steps/sequencing and timeframes would be appropriate to facilitate a smooth transition?

Ongoing engagement, through impact analysis and report release, with the sector will be required to garner practical suggestions and timelines to successfully implement Model 1 achieving the benefits described on page 18 AND to minimising the risks described on page 19 of the Paper.

A timeline for change is required, including allowing for further ACAR rounds prior to implementation of any changes to the allocations process for residential aged care.

If a decision is made to implement Model 2, the types of strategies listed in Model 1 could become the interim or transitional stage, in an overall three to four-year implementation process.

Model 2. Assign residential care places to consumers

Overall what are your views of this model?

Model 2 proposes that Approved Providers:

1. Can deliver residential aged care to anywhere in Australia
2. No longer need to obtain places through ACAR or through transfer from other providers to deliver residential aged care
3. Can deliver residential aged care to as many eligible consumers who have been assigned places as they can attract and viably provide for

The allocation of aged care places would no longer be assigned to approved providers but rather directly to consumers who have been assessed as eligible for residential aged care.

We offer in principle support to Model 2 as it appears consistent with the direction of the Roadmap in that it is:

- *Consumer driven* in that it shifts the allocation of a residential aged care place direct to the consumer, allowing them to search for and locate an approved provider that delivers the service they are looking for at the price they are willing to pay; and is
- Market based as approved providers would be able to make business decisions, based on assessment of market demand and unmet need, to deliver residential aged care services in any region in Australia.

Ongoing engagement, through impact analysis and report release, with the sector will be required to garner practical suggestions and timelines to successfully implement Model 2 achieving the benefits described on page 26 AND to minimising the risks described on the same page.

The continuation of existing mechanisms (such as the RRR supplement and accommodation payments) must occur to ensure concessional (low-means) residents continue to receive services in the new model.

The impact analysis that is occurring should consider whether the changes proposed in the Models may impact the balance or mix of for-profit and not-for profit providers in the sector, and if so, what might be the effects of such an impact. A review of changes that have occurred in similar or 'like' markets (New Zealand would be a salient example[23]) where a move towards deregulation of licenses has occurred, would likely be instructive.

[23] It may be useful to understand what the learnings from New Zealand are where changes to bed licensing arrangements has occurred – Has the 'provider profile' changed post deregulation?

- Are there provider types that were disadvantaged under the changes and if so how?
- Did the cost of 'doing business' change, if so how?
- Are any particular consumer segments disadvantaged and if so, how has this been responded to?
- What corrective measures have had to be put in place to address market failures?

Creation and design of a prioritisation queue

The proposal in Model 2 to create a prioritisation queue for residential aged care prompts a number of initial comments:

- With occupancy sitting around 94 per cent nationally[24] we question the need for a prioritisation queue, were we to get to a situation where demand exceeds availability, we would then support consideration of the best way to implement a prioritisation process
- Noting the above point, were a prioritisation process introduced it, would provide a means to determine demand for residential aged care places, in much the same way that the implementation of a prioritisation queue has done this for the Home Care Packages Program
- Again, were a prioritisation process implemented (in a market where demand exceeds availability), then once allocated a residential aged care 'place' a consumer should have a set period (for example 28 days) within which to take up or relinquish the place. Once a place is declined, the consumer should have the ability to re-enter the prioritisation process without disadvantage. The relinquished place would then be reallocated to another consumer

A centralised prioritisation process may slow down the speed in which people who need care are able to access vacancies. Creation of a prioritisation process must not negatively impact the ability to fill a vacant place in a timely manner i.e. where a provider has a vacancy available and where there is a consumer who wishes to enter that service, then there must be a process where that consumer can gain an approval of a 'place' in a timely manner.

ACSA broadly agrees with the factors listed on page 22 in the Paper that would need to be in place if a prioritisation queue were to be implemented[25].

The Paper describes that under Model 2 approved providers would have the ability to 'accept or reject[26]' consumers. This is vital to ensure that providers only accept individuals whose care needs they can appropriately meet.

Supporting sector sustainability in a competitive market and financing sector growth

Overall Australia needs a sustainable aged care sector able to provide quality services to all who need it regardless of where they live or any special needs they may have. This is currently under threat, particularly in rural and remote Australia, as a result of an inadequate quantum of funds compounded by inadequate indexation.

However, in relation to the proposed changes we make the following observations:

- Changes proposed in Model 2 are likely to be more disruptive (than Model 1) to the sector as it:
    - Removes locational controls and allow providers to expand across the country delivering services to as many consumers as they can attract and can viably provide for which s will create 'competition' pressures. This is likely to result in

[24] Residential aged care: proposed alternative models for allocating places, Discussion paper, University of Technology, Sydney, July 2019, p7

[25] Factors listed for a prioritisation framework include date of approval for residential aged care, date of actively seeking a residential place, urgency of need and other factors.

[26] Residential aged care: proposed alternative models for allocating places, Discussion paper, University of Technology, Sydney, July 2019, p23

some services becoming unviable or providers deciding to exit the system. This needs to occur on a planned way to ensure there is no negative impact for consumers and communities.

- Reduces income certainty for approved providers and threatens ability of some, not just poorly performing providers, to continue operating. Allocating places to consumers will likely impact on the way financers (Banks) to the sector view lending risk, this may impact the 'cost' of finance. This needs to be worked through to ensure ongoing sector viability and availability in some areas

- Approved providers may need to assess the way they manage 'intangible assets', understanding that many not-for-profit providers no longer place a book value on approved beds
- With less certainty in relation to occupancy, providers may need to address new and more flexible staffing and industrial arrangements
- Changes proposed in the Models must not negatively impact overall sector sustainability further (understanding that the impact analysis study is likely more concerned with sustainability of the sector at a macro level rather than individual provider-level sustainability)
- If increased exits from the sector is an anticipated outcome of the proposed changes, strategies must be developed that ensure that, as far as practical, 'orderly exists' occur[27]
- The Aged Care Financing Authority has previously articulated that growth of 88,000 residential aged care places is anticipated over the coming decade, with an investment in the order of $54 billion required

The impact analysis being undertaken must address these, and other identified potential impacts. The report to government must include mitigation and management strategies to support the sustainability of the sector and ensure ongoing access for consumers to residential aged care across all regions of Australia.

Ensuring that aged care is an attractive investment option, for existing and potential new investors, needs to be a key design principle.

Financial sustainability of rural, regional and remote providers, as well as providers of services to special needs groups (such as dementia, CALD, homeless etcetera) must be considered as part of the impact analysis that is underway.

Encouraging service provision in thin markets

Caution is needed when considering changes that reduce locational controls, particularly allowing places to be moved out of the region that they were originally allocated to and where the places have been allocated to particular population groups. Changes to current 'allocation of places' arrangements must must not decrease sustainability and viability in regions where normal market corrections do not work.

Residential aged care services in regional, rural and remote areas are often the sole services available to consumers, they are often significant employers in their communities and should

[27] If increased exists of 'poor performing' providers is a possible outcome of Model 2, consideration must be given to improved transparency and visibility of the financial performance of providers by the Department of Health as part of their prudential management oversight responsibilities (for further commentary on prudential oversight see ACSA Submission to the Department of Health, Review of Refundable Accommodation Payments, March 2019). A concern to the sector will be the risk of increased default events relating to refundable accommodation moneys, with an associated increased risk of the imposition of the now mandatory levy scheme for defaults events over $3M in any financial year.

they fail to exist, the risk is they will not be replaced. This creates the risk of significant social dislocation should residents have to move away from their local communities.

Likewise, providers delivering services to special needs groups must also be protected.

The impact analysis should consider whether the proposed changes should even apply to 'thin markets'. It may be appropriate that such regions are treated differently to ensure vital services remain available in local communities, acknowledging that it is unlikely that new providers would enter more rural and remote areas. The MMM tool could be used to determine appropriate areas for such an exemption. Separate strategies, including looking at block funding on locational and population group bases.

The impact analysis work that is undertaken by UTS must identify and recommend strategies that ensure:

- Regional, rural and remote services are sustainable
- Services to special needs groups are sustainable
- Protections for concessional (low-means) residents are in place, and ongoing incentives are provided to approved providers to continue to deliver a significant proportion of their services to low-means people.

Strategies could include:

- Providing financial incentives to provide respite services in thin markets
- Block funding services in rural and remote locales (criteria could be based on the Modified Monash Model[28])
- Funding services based on bed numbers rather than on occupancy (this may be more problematic in an environment where places are no longer allocated to providers)
- Providing incentives (i.e. supplements) to providers who provide 'special needs' services to consumers

Residential respite care

ACSA strongly supports respite services being an integral component of aged care service provision. Respite care needs to be allocated, planned and funded in a way which means it can be provided both on a planned and emergency basis. This must take account of the fact that there are increased:

- Vacant bed days with respite beds (late cancellation of planned respite visits being one common cause)
- Costs associated with the higher staff inputs required because of the short-term nature of respite, meaning more residents to enter and settle, accompanies the provision of respite services

[28] https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model

Mechanisms to address this could include:

1. One-off adjustment payments[29] to providers for each respite resident to assist with assessing and supporting respite residents as they enter the aged care service
2. The new Integrated Carer Support Services or an equivalent centralised service that facilitates planning and funding
3. Incentive payments to approved providers to encourage the provision of planned and emergency respite places, this could include for example:
    - Mechanisms to fund, or at least compensate, for vacant beds days associated with providing a respite service
    - A review of the supplements that are available to providers (including the residential respite supplement, and the respite incentive supplement) to ensure adequate compensation for the inability to gain either a RAD or DAP[30] payment for a bed allocated to respite

This process is an opportunity to develop and implement strategies that actively support respite provision, As more and more people elect to age at home the demand for all forms of respite, including residential, will only increase. It will be important that the impact analysis ensures there any change will not make the provision of respite less likely.

In an environment where 45 per cent of providers (up to 63 per cent in rural and regional areas) are actively experiencing an operating loss[31] further financial discouragement to approved providers to deliver respite services cannot be afforded.

Extra services and additional services places

ACSA is currently participating in a separate stream of work with the Department of Health looking at the provision of additional services which is still unclear.

For some years there have been no extra service places rounds partly due to all places now being able to attract RADs and the creation of additional services which were seen to offer the possibility of offering to all places what had previously been restricted to extra services. A number of approved providers are relinquishing extra services and transitioning to the provision of additional services.

This work needs to be taken in to account in this research and the analysis impact to ensure there are no unintended consequences.

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[29] A one-off adjustment payment could be modelled on the adjustment payment proposed in the Resource Utilisation and Classification Study, p12: (AN-ACC: A funding model for the residential aged care sector, The resource Utilisation and Classification Study: Report 5, University of Wollongong, February 2019). The Study highlighted that there is 'clear evidence that costs are higher in the initial adjustment period, p13). Such a payment is compensation for the additional resources required to:

- Spend time getting to know the resident
- Individualised care planning
- Health care assessments etc. (p12)

[30] https://agedcare.health.gov.au/aged-care-reform/residential-care-and-home-care-frequently-asked-questions

[31] StewartBrown Aged Care Sector 2018 Financial Year Report, October 2018

Capital grants

Continuation of the Capital Grants program[32] continuing under the proposed Models is vital and must continue into the future.

Criteria for capital grants, including priority criteria for allocation of grant moneys (regional rural and remote or special needs groups being examples), should continue to be detailed and available to the sector.

Implementation and transition considerations

A clear and detailed transition plan needs to be developed in conjunction with the sector regardless of which model is ultimately implemented. Key considerations for a transition plan agreed between government and the sector should include:

- Agreement to the timeframe required by the sector to successfully transition, this is likely to be somewhere between three to four years[33] following government making a decision and announcement
- Transition should provide for further ACAR rounds until the transition is complete
- A number of current providers may choose to leave the sector – a process for 'orderly exists' will need to be in place to ensure continuity of care for residents
- Changes required in government systems and processes (ICT, payment systems etcetera) need to be carefully timed and bedded down to avoid any failures
- Changes required to regulatory and legislative frameworks

Providers will need time to consider and address a range of factors including, but not limited to:

- Consideration of impacts on their business model, including factors such as the treatment of intangible assets
- The impact on development/re-development/expansion plans that are already in progress
- Workforce impacts/models in an environment where occupancy and funding may be more variable

Implementation of a new Model and subsequent transition planning will need to take into consideration concurrent reforms and other key sector activities, for example:

- Prudential arrangements, see here
- Residential aged care funding model, see here
- Royal Commission into Aged Care Quality and Safety, see here

It is critical that an overall approach is developed which analyses and considers these major reforms. Changes in one area will impact on another. This needs to be carefully and deliberately done to ensure older Australians can continue to access quality residential care when and where they need to.

[32] https://agedcare.health.gov.au/aged-care-funding/capital-funding

[33] The length of any transition period will depend on the degree of change implemented, i.e. a shorter transition timeframe for a Model 1 outcome and a longer transition period for a Model 2 outcome.